CareSource Just4Me Healthcare with Heart (Silver 2-B)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/15 – 12/31/15

Coverage for: Individual | Plan Type: HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.caresource.com/just4me] or by calling [1-888-815-6446].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000 Individual / $2,000 Family per Benefit Year. Deductible** does not apply to Copayments, Physician Home and Office Services for Primary Care, Physician Home and Office Services for Specialty Care, Prescription Drugs, Preventive Health Services, Urgent Care Services and Vision Services-Pediatric.	You must pay all the costs up to the **Deductible amount before this plan begins to pay** for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **Deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,000 Individual / $4,000 Family**	The **Out-of-Pocket Limit** is the most you could pay during a coverage period for your share of the cost of covered services. Copayments and coinsurance are applied toward the out-of-pocket limit. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed charges and health care services that are not covered by this plan.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes how the plan and you will pay for *specific* covered services.
Does this plan use a network of providers?	Yes. For a list of network providers,	If you use an in-network doctor or other health care **Provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use

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OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146 Released on April 23, 2013 (corrected)

	see www.caresource.com/just4me or call 1-888-815-6446.	an out-of-network **Provider** for some services. Plans use the term in-network, **Preferred** or participating for **Providers** in their network. See the chart starting below for how this plan pays different kinds of **Providers**.
Do I need a referral to see a specialist?	No.	You can see the Network **Specialist** you choose without permission from the plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **Excluded Services**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health	Primary care visit to treat an injury or illness	$0/visit	Not covered.	No **Deductible**. You only pay the **Copay**.

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
care provider's office or clinic	Specialist visit	$0/visit	Not covered.	Plan covers 100% of **Allowed Amount** in excess of the **Copay**. **Copayment** waived when the only charge is for allergy injections/serum. If you receive services in addition to office visit, additional **Copays**, **Deductibles** or **Coinsurance** may apply.
	Other practitioner/chiropractic office visit	10% Coinsurance after deductible	Not covered.	Manipulation therapy limited to 12 visits per Benefit Year.
	Preventive care/screening/immunization	No charge	Not covered.	Services must meet requirements as determined by federal and state law.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance after deductible	Not covered	
	Imaging (CT/PET scans, MRIs)	$150/procedure after deductible	Not covered.	Prior Authorization Required.

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	Preventive drugs	Retail: $0 copay Mail-Order: $0 copay	Not covered.	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caresource.com/just4me	Generic drugs	Retail: $0 copay Mail-Order: $0 copay	Not covered.	There is no **Deductible** for prescription drug coverage You only pay the **Copay/Coinsurance**. Retail: up to a 31-day supply. Mail-Order: up to a 90-day supply. Certain drugs may require a prior authorization. You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs
	Preferred brand drugs	Retail: $30 copay Mail-Order $62.50 copay	Not covered.	
	Non-preferred brand drugs	Retail $70 copay Mail-Order $175.00 copay	Not covered.	
	Specialty drugs	40% Coinsurance (retail and mail-order)	Not covered.	$150 maximum Coinsurance.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance after deductible	Not covered.	Prior Authorization Required.

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	Physician/surgeon fees	10% Coinsurance after deductible	Not covered.	
If you need immediate medical attention	Emergency room services	$300/visit after deductible	$300/visit after deductible	**Copay** waived if you are admitted to the hospital directly from the Emergency Department.
	Emergency medical transportation	10% Coinsurance after deductible	10% Coinsurance after deductible	Prior Authorization required for air or water transportation or non-emergency health services.
	Urgent care	$0/visit	$0/visit	If you receive services in addition to urgent care, additional copays, deductibles, or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$300/stay	Not covered.	Prior Authorization Required.
	Physician/surgeon fee	10% Coinsurance after deductible	Not covered.	None

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$0/visit for office visits and 10% Coinsurance after deductible for other outpatient services	Not covered.	Prior Authorization required for all inpatient stays, partial hospitalization programs and intensive outpatient services.
	Mental/Behavioral health inpatient services	$300/stay after deductible	Not covered.	
	Substance use disorder outpatient services	$0/visit for office visits and 10% Coinsurance after deductible for other outpatient services	Not covered.	
	Substance use disorder inpatient services	$300 /stay after deductible	Not covered.	
If you are pregnant	Prenatal and postnatal care	$0 copay	Not covered.	Copay covers initial physician visit and all subsequent prenatal visits, postnatal visits, and physician delivery charges covered under the Global maternity fee. Additional copays, deductibles, or coinsurance may apply depending on services rendered in addition to the Global maternity fee.

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	Delivery and all inpatient services	$300/stay after deductible	Not covered.	Your cost for inpatient services only. See above for physician delivery charges.

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If you need help recovering or have other special health needs	Home health care	10% Coinsurance after deductible	Not covered.	Limited to one hundred (100) combined visits per benefit year.
	Rehabilitation services	$0 copay for PT/OT. All other, 10% Coinsurance after deductible	Not covered.	Twenty (20) visit limit applies to each of physical therapy, occupational therapy, speech therapy and pulmonary rehab. Thirty-six (36) visit limit for cardiac rehab. Twelve (12) visit limit for spinal manipulation. Home health care limits apply when services are rendered in the home.
	Habilitation services	10% Coinsurance after deductible	Not covered.	Habilitation services are subject to the visit limits described in "Rehabilitation Services," which is a combined limit for Habilitation and Rehabilitation services.
	Skilled nursing care	$100/stay	Not covered.	Any combination of benefits for skilled nursing facility/inpatient rehabilitation facility services is limited to 90 days per calendar year.
	Durable medical equipment	10% Coinsurance after deductible	Not covered.	May require prior authorization.
	Hospice service	No charge	No charge	Prior Authorization required. This benefit is not subject to deductible.
If your child needs dental or eye care	Eye exam	No charge	Not covered.	Limit of one routine eye exam per benefit year.

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	Glasses	No charge	Not covered.	Limited to 1 pair per benefit year and 1 replacement pair if medically necessary.
	Dental check-up	Not covered.	Not covered.	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids to adults
- Long-term care
- Non-emergency care when traveling outside the U.S
- Routine foot care
- Weight loss programs.

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Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic Care
- Infertility treatment

Your Rights to Continue Coverage:

Federal and state laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-815-6446. You may also contact your state insurance department at 1-800-595-6053.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact 1-800-595-6053.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays: $6,030**
- **Patient pays: $1,510**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$300
Coinsurance	$60
Limits or exclusions	$150
Total	**$1,510**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays: $4,220**
- **Patient pays: $1,180**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$100
Limits or exclusions	$80
Total	**$1,180**

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**,

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and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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